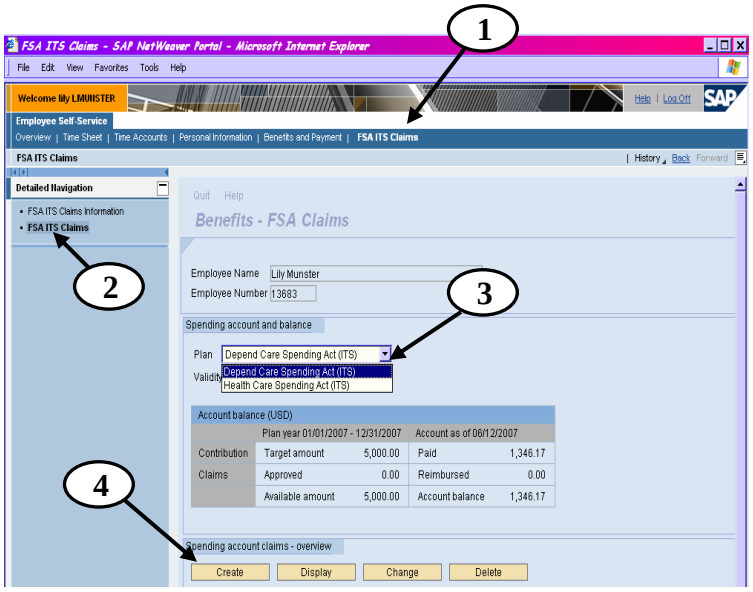
# FSA/ITS Online Claims Process

1. Click on ***FSA ITS Claims***
2. Click ***FSA ITS Claims***
3. Choose a plan from drop-down menu
   - ***Depend Care Spending Act (ITS)***
   - ***Health Care Spending Act (ITS)***

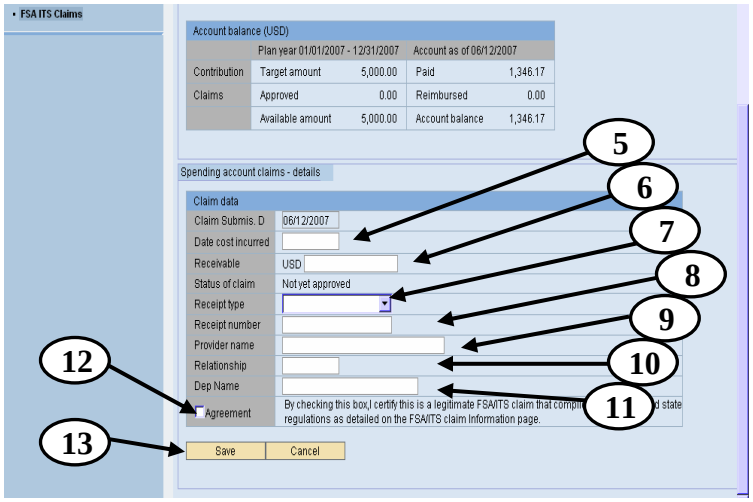
   You will only see plans which you are enrolled.
4. Click ***Create*** to start a new claim




Complete the following fields

5. Date cost incurred – Date services performed
6. Receivable – Amount paid – no dollar sign
7. Receipt Type – Choose from drop-down menu
8. Receipt number – Free fill, your information
9. Provider name – Doctor, pharmacy, etc

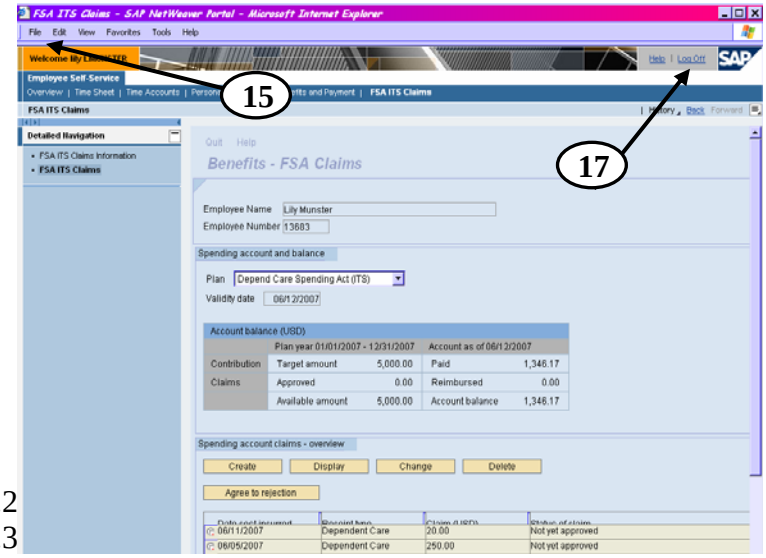
   Dependent Care must include Tax ID or SSN.
10. Relationship – Relationship to employee
11. Dep name – Name of dependent
12. Check box – Read and agree prior to submitting a legitimate claim
13. Click ***Save*** to continue




14. You will see this screen and will click ***OK*** to continue


**<u>Print a copy of the summary screen, attach copies of receipts, sign and send to the Auditors office for payment</u>**

15. Click on the ***File➔Print***
16. Choose the printer you want to print from and click ***OK*** to continue
17. Click the ***Log off*** button when you are done with your claims
18. Click on ***Yes*** button to verify that you are ready to log off
19. You have completed a FSA/ITS Claim online



# Dependent Care Spending Account Information

**Completing a Claim**
Complete all sections of the claims detail. You must print the claims summary sheet, sign, and attach copies of the receipts prior to sending to the Auditors-Controller's Office for payment.

1) Submit only expenses that are reimbursable under the Dependent Care Spending Account. Expenses may be reimbursed only for services that make it possible for you to work. If you are married, your spouse must be a wage earner, a full-time student for at least five months during the year, or disabled.

2) **Date** – Enter the date in which care was provided. This date must occur during your participation in the plan.

3) **Amount/Receivable**– Enter the amount to be reimbursed from your account.

4) **Receipt Type** – Dependent care

5) **Receipt Number** – Free form field to be used for your notes.

6) **Provider Name** – Enter the name of child or adult dependent care center or the name of the individual providing care, as well as the provider's Social Security or Tax Identification Number (TIN).

7) **Relationship** – Indicate spouse, son, daughter, or other dependent, such as mother, father, sister, brother.

8) **Dep Name** – Enter the first and last name of the person who received the care for which expenses are being submitted.

**Attaching your bills and records**
When you submit your request for reimbursement you must also provide copies of itemized bills or receipts that clearly state each of the services and supplies provided including:

- name of person or organization providing the care
- name of the person receiving the care
- dates that care was provided
- total charge for the care

***Note:*** Canceled checks are not acceptable receipts

**Submitting your request**
Send the Dependent Care reimbursement summary sheet and copies of your bills to the Auditor-Controller's Office, Room D220, County Government Center, San Luis Obispo, CA 93408.

If you have any questions about how to complete this form, or what bills to submit, contact the County's Risk Management Department at (805) 781-5011.

# Health Care Spending Account Information

**Completing a Claim**
Complete all sections of the claims detail. You must print the claims summary sheet, sign, and attach copies of the receipts prior to sending to the Auditor Controller's Office for payment.

1) Submit only expenses which are reimbursable under the Health Care Spending Account. These include expenses not paid by any medical or dental insurance plan. Eligible expenses include:

    - deductibles (your front-end medical and dental costs)
    - co-insurance (your share of the medical and dental expenses)
    - routine physical examinations
    - deductibles and co-payments for eyeglasses, contact lenses, hearing aids plus the cost of exams associated with their prescription
    - any healthcare service or supply which you could *otherwise* use as a tax deduction (Insurance premiums for any health insurance other than your employer's, are not reimbursable)

2) **Date** – Enter date on which service or supplies were received. This date must occur during your participation in the plan.

3) **Amount/Receivable**– Enter the amount to be reimbursed from your account. This amount should include only that portion of the expense that was not eligible for payment by any insurance plan.

4) **Receipt type** – Use the drop-down menu to enter the type of service or supplies for which reimbursement is requested.

5) **Receipt Number** – Free form field to be used for your notes.

6) **Provider Name** – Enter the name of child or adult dependent care center or the name of the individual providing care, as well as the provider's Social Security or Tax Identification Number (TIN).

7) **Relationship** – Indicate spouse, son, daughter, or other dependent, such as mother, father, sister, brother.

8) **Dep Name** – Enter the first and last name of the person who received the care for which expenses are being submitted.

**Attaching your bills and records**
When you submit your request for reimbursement you must also provide copies of itemized bills or receipts that clearly state each of the services and supplies provided including:

- name of person or organization providing the service or supplies
- name of the person receiving the service or supplies
- date that service or supplies were provided
- total charge for the service or supplies
- description of the service or supplies – bill for prescription drugs must include prescription number, date of purchase, and name of prescribing physician

***Note:*** Canceled checks are not acceptable receipts

**Submitting your request**
Send the Health Care reimbursement summary sheet and copies of your bills to the Auditor-Controller's Office, Room D220, County Government Center, San Luis Obispo, CA 93408.

If you have any questions about how to complete this form, what bills to submit, or about your Health Care Spending Account, contact the County's Risk Management Department at (805) 781-5011.